New Hampshire Medical Eligibility Determination (MED) Application

Last:	First:	MI: MID:	Da	ite:	
Referral Source: Applicant Family	☐Guardian ☐Nursing Facility	☐Physician ☐Other	□Powe	r of Attorney	
Referral Agency/ Organization:		Name:	Pł	hone:	
Is this a transfer from a hospital to a Nursing Facility?					
Name of the facility requesting tran	sfer:	Contact person:	Ph	hone:	
Projected Transfer/Discharge Date	:	Is this a Medicare transf	fer?	No	
(Office Use Only) Assessment Trigger: ☐ 1. New Applicant: ☐ 2. Reas	LTC Nurse: _		Pł	hone:	
Long Term Care Counselor:	ServiceLlnk:		District Office:		
DEMOGRAPHICS 1. SSN 2. DOB 6. Mailing Address: (primary residence of the street)	4. Age	☐ female 5. ☐ MR/I	DD	II	
City	Zip Pho	one Cou	unty		
7. Secondary Address: (if indicated for legal guardian) Street City Zip Phone					
8. Marital Status: 1. Never married 2. Married	☐ 3. Widowed ☐ 4. Separated	☐ 5. Divor ☐ 6. Civil			
9. Primary Language: ☐ 1. English ☐ 2. Spanish	☐ 3. French ☐ 4. Other: Specify: _				
10. Communication: 1. No assist necessary 2. Requires Asst. Device 4. Other: Specify					
of re 1. Own Home 2. Another's Home 3. Adult Family Home 4. Assisted Housing 5. Congregate Housing 6. Homeless	al place sidence Assessment	7. Hospital 8. Hotel/Motel 9. Nursing Facility 10. Residential Card 11. Other: Specify	A. Usual place of residence □ □ □ □ □ □	B. Location at Assessment	
12. Usual Living Arrangements: Lives with (check all that apply) ☐ a. Alone ☐ b. w/spouse ☐ c. w/family ☐ d. w/others ☐ e. # in household ☐					
13. Medicaid Status: Yes No 1. Application filed? Application date: Yes No 2. Eligible? Yes No 3. Eligibility pending?					
, ,, <u> </u>	ddress	Phor Last	ne visit date		
Type: ☐ Specialist N	 lame	Phor	ne		

Last:	First:	MI: MID: Date:		
	Address	Last visit date		
Type: Dentist	Name Address	Phone Last visit date		
Type: Eye Doo	tor Name Address	Phone Last visit date		
15. Responsibility/Legal Guardian: (must have supporting documentation) 1. Self				
16. Advance Directives: (only for those items ☐1. Living will ☐2. Organ donation ☐3. Other		tation) On not resuscitate		
17. Emergency Contact: Name Address	Legal Name Addre	Guardian: Other Contact: Name Address		
Phone	Phone Relati	Phone Relationship		
I understand that I am agreeing to apply for a Medicaid program - Choices for Independence or Nursing Facility Care.				
I understand that if I am not already a Medicaid recipient, I must become Medicaid eligible in order to receive services from the Choices for Independence program. I must also become Medicaid eligible if this will be the source of payment for Nursing Facility services.				
I understand that I will participate in a Medical Eligibility Determination assessment, which is an interview conducted by a Registered Nurse in my home or current place of residence.				
My signature below indicates my understanding of the application process and my desire to participate in the program.				
SIGNATURES:				
Applicant:		Date:		
Representative:		Date:		
Relationship to Applicant:				
(Office Use Only) Long Term Support Counselor:				
If the information for this application was gathered from a telephonic interview, indicate below and mail a copy of this application with the regular packet of information, requesting the form to be returned with the signature:				
☐Telephonic Interview □	Date:	LTSC Signature:		
[Date Mailed:	Date Returned:		